

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 393030	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 12/14/2022
NAME OF PROVIDER OR SUPPLIER: ALLIED SERVICES INSTITUTE OF REHABILITATION MEDICINE			STREET ADDRESS, CITY, STATE, ZIP CODE: 475 MORGAN HIGHWAY SUITE A SCRANTON, PA 18508		
STATE LICENSE NUMBER: 016901					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 0000	<p>INITIAL COMMENT</p> <p>This report is the result of an occupancy survey conducted on December 14, 2022, at Allied Services Institute Of Rehabilitation Medicine which included closure of the pool services located at 475 Morgan Highway Scranton, PA 18508. Based on the survey, it was determined the facility was in compliance with the requirements of the Pennsylvania Department of Health's Rules and Regulations for Hospitals, 28 Pa Code, Part IV, Subparts A and B, November 1987, as amended June 1998.</p>		P 0000		

(X6) DATE:



Certified End Page

ALLIED SERVICES INSTITUTE OF REHABILITATION MEDICINE

STATE LICENSE NUMBER: 016901

SURVEY EXIT DATE: 12/14/2022

**I Certify This Document to be a True and Correct Statement of Deficiencies and
Approved Facility Plan of Correction for the Above-Identified Facility Survey**

A handwritten signature in black ink that reads "Jeane Parisi".

Jeane Parisi
Deputy Secretary for Quality Assurance

A handwritten signature in black ink that reads "Debra L. Bogen MD".

Debra L. Bogen, MD, FAAP
Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY